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ABSTRACT

This chapter addresses questions about the utility of family work as a separate discipline distinct from other helping professions. Empirical evidence is presented that supports the effectiveness of family involvement in treating childhood and school problems, psychotic disorders, mood disorders, anxiety disorders, physical health problems, dissociative disorders, and substance-related disorders. The evidence suggests that incorporating family work into counseling is effective because it allows a counselor to address the client's familial and social environment. It is noted that family counseling is not a replacement for individual or group counseling, but rather a supplement and support for other counseling approaches. (Contains 25 references.) (GCP)

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Why Incorporate Family Counseling into Your Practice?

by

David M. Kaplan

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Chapter One

Why Incorporate Family Counseling Into Your Practice?

David M. Kaplan

"Counselors recognize that families are usually important in clients' lives and strive to enlist family understanding and involvement as a positive resource, when appropriate."
American Counseling Association Code of Ethics
and Standards of Practice

Family intervention has come full circle. Both couples/marriage and family counseling began as a sideline for physicians, ministers, psychologists, lawyers, social workers, and teachers (Gurman & Kniskern, 1981). Practitioners in each of these professions saw that family problems were intertwined with a variety of legal, religious, medical, psychological, sociological, and educational issues. An interesting example from the mid-1960s comes from pediatricians working with diabetic children at the Children's Hospital of Philadelphia (Baker, Minuchin, Milman, Liebman, & Todd, 1975). When a child was first diagnosed with diabetes, one of the staff pediatricians would sit down with the patient and his or her parents

to review nutritional requirements and protocols for taking insulin. Most families were able to follow these instructions and keep the child in good health. Some of the children, however, would show up in the emergency room with episodes of ketoacidosis, a potentially life-threatening condition that occurred when the children stopped taking insulin and their blood sugar skyrocketed. After each emergency, the child's pediatrician would again sit down with the child and parents, point out the seriousness of ketoacidosis, and review the insulin protocols. After this review, most children took their insulin and kept their blood sugar in check. A certain number of diabetic children, however, continued to show up in the emergency room on a regular basis. The pediatricians decided to find out why.

The answer lay in family dynamics. The children with repeated ketoacidosis episodes had one characteristic in common: they came from homes where the mother and father experienced significant conflict. When Mom and Dad would fight, the child would become frightened that the family would break apart, stop taking insulin, and end up in a hospital bed. At that point, the worried parents would act as a team, focusing on the health and well-being of their son or daughter. Unfortunately, the ketoacidosis was only a distraction that did not resolve the ongoing conflicts between Mom and Dad. Therefore, once the child was home and the emergency had passed, the parents resumed fighting. Then the cycle started all over again, as the child would again sabotage his or her insulin regime in order to create an emergency that would distract Mom and Dad from problems that threatened to cause a separation or divorce.

This example illustrates why practitioners from various disciplines discovered that involving relatives of their patients, clients, parishioners, or students could be helpful. The emergence of couples/marriage counseling and family therapy as related specialties led to the formation of the American Association for Marriage Counselors in 1942. The association changed its name to the American Association of Marriage and Family Counselors in 1970, and became the American Association for Marriage and Family Therapy in 1978. The latter name change marked the point when many practitioners of

family work began to view family therapy as a separate discipline distinct from other helping professions. It also marked a time when outcome research came into focus. Enough research has now been generated to allow us to answer questions about the utility of family work.

Is Family Work Supported by Research?

Although not everyone is unanimous that marriage/couples counseling and family therapy (MFT) are efficacious (see Baldwin & Huggins, 1998), research demonstrates that outcomes are as good as or better than in most areas of psychotherapy (Shadish, Ragsdale, Glaser, & Montgomery, 1995). Substantial clinical data support the use of family interventions (Carlson, 1993). Various reviews of the family therapy literature have expressed this theme:

> Judging from our recent meta-analysis . . . it is clear that marital and family therapy works. (Shadish et al., 1995, p. 345)

> The efficacy of marital and family therapy has been well supported by clinical research. (Carlson, 1993, p. 64)

> MFT works . . . [and] is not harmful. MFT does not appear to have negative or destructive effects. In all of the research reviewed, there has not been one replicated and controlled study in which patients and families receiving family or marital therapy had poorer outcomes than patients receiving no therapy. (Pinsof & Wynne, 1995, p. 604)

> Marriage and family therapy outcome research has repeatedly supported the use of family-contextual interventions for a variety of presenting problems, including those traditionally treated with intrapsychic individual psychotherapy. The outcome results indicate success over a broad scope of practice for marriage and

> family therapy, especially when used in collaboration with other treatment modalities. (Baldwin & Huggins, 1998, p. 212)

What is the "broad scope of practice" that Baldwin and Huggins refer to in the preceding quotation? It refers to research showing that a treatment plan incorporating family counseling is more effective than one using individual counseling alone in addressing a wide range of problems including childhood disorders, drug and alcohol abuse, mood disorders, eating disorders, psychosis, physical illness, and obesity (Pinsof & Wynne, 1995). Family work has also been found to increase the efficacy of standard treatments for anxiety disorders (Nathan & Gorman, 1998). There is also empirical evidence to support the effectiveness of family involvement in treating psychosomatic illnesses, school problems, dissociative identity disorder, traumatic brain injury and, as would be expected, family conflict and divorce complications (Carlson, 1993).

Childhood and School Problems

A significant body of literature supports the use of family counseling in treating childhood disorders. In a literature review of studies regarding children with a psychiatric diagnosis, Estrada and Pinsof (1995) concluded that children diagnosed with oppositional defiant disorder, conduct disorder, attention deficit disorder, school phobia, and autism improve when family counseling is incorporated into treatment.

Research conducted by Morrison, Olivos, Dominguez, Gomez, and Lena (1993) focused on evaluating a family systems approach in an elementary school setting. Thirty multicultural families (25 Hispanic, 4 Anglo, and 1 African American) participated in a team effort to address such issues as refusal to do homework, fighting, abusive language, truancy, tardiness, stealing, and emotional outbursts. Parents attended from one to seven team meetings. The results indicated that school-related behavior improved in 67% of

the students in the program. Impressively, the vast majority of the students who improved (93%) did not relapse over a two-year period.

Campbell and Patterson (1995) reviewed the literature on pediatric obesity and found that family work is a crucial component in helping children maintain long-term weight loss. With regard to studies of childhood physical illness, the same authors concluded that incorporating family counseling into medical treatment had significant physical and psychosocial benefits for children with chronic illnesses such as severe asthma, diabetes, and recurrent abdominal pain. A third area the authors focused on was adolescent eating disorders. Their summary of the literature revealed that adolescents diagnosed with anorexia nervosa gained significantly more weight when family work was a component of their counseling as compared with when they received individual counseling only.

Psychotic Disorders

Adding a family component also appears to increase the effectiveness of therapeutic approaches to psychosis (Goldstein & Miklowitz, 1995). This finding makes intuitive sense, given that "it has been well established that marital and family processes and affective illnesses are significantly and complexly interrelated" (Prince & Jacobson, 1995, p. 395). Falloon, Hole, Mulroy, Norris, and Pembleton (1988) developed a behavioral family therapy model for families of individuals diagnosed with schizophrenia. Their approach incorporates an educational component in which family members learn about the nature of schizophrenia, as well as how to recognize early symptoms of the condition in order to monitor medication compliance. A third family component is training in stress management techniques.

Mood Disorders

Research has indicated that a family therapy component increases the effectiveness of treatments for mood disorders. In their literature review, Baldwin and Huggins (1998) found that incorporating family

work into outpatient treatment was particularly useful for clients with depression who felt that their family life contributed to their mood disorder. Frank and Kupfer (1986) reported better compliance with treatment regimes for depression when a family psychoeducational component was included. There are also data to indicate that adding family counseling to a standard regime with patients hospitalized for bipolar disorder increases the efficacy of treatment (Baldwin & Huggins, 1998). This conclusion is in keeping with research indicating that the level of stress in a family is predictive of the prognosis for relapse in bipolar disorder (Nathan & Gorman, 1998). Finally, research by O'Leary and Beach (1990) indicates that behavioral marital therapy is more effective than individual cognitive therapy in treating depression when marital distress is a major contributor to the depression.

Anxiety Disorders

Nathan & Gorman (1998) describe an interesting study from India regarding obsessive-compulsive disorder (OCD; see Mehta, 1990). Thirty unmarried young people who had been diagnosed with OCD unresponsive to pharmacological treatment were selected for the investigation. All participants received 24 sessions of systematic desensitization over a period of 12 weeks. Half were randomly assigned to a group that received family work as part of the treatment. Participants in the family group designated one member of their immediate family to help with homework assignments, supervise relaxation training, aid in response prevention, and provide support when the participant became anxious or depressed. Treatment efficacy was evaluated at the end of the 12-week treatment regime and 6 months later. Results indicated that participants who received systematic desensitization alone reduced their OCD symptoms by 39% at the end of treatment and by 29% after six months. In contrast, the participants who received family assistance in addition to the systematic desensitization showed a 56% reduction in symptoms at the conclusion of treatment and a 61% reduction after six months. It is interesting that the family component resulted in a 17% greater

gain immediately post-intervention. But it is even more interesting that the treatment produced an additional 5% reduction in symptoms six months later whereas participants who did not receive the family component reported a 10% *increase* in symptoms over the same time. It appears that the former group may have learned the benefits of including relatives in a treatment regime and continued to utilize family support and assistance on a long-term basis.

Physical Health

There is strong empirical evidence to support a family component in treating physical illnesses and promoting physical health. Campbell and Patterson (1995) reviewed health intervention research in family therapy, family psychoeducation, family information and support programs, and programs that provide direct services to an entire family. They concluded that a family approach (especially one with a psychoeducational component) is more effective than an individual approach in treating physical illnesses such as asthma, diabetes, abdominal pain, chronic illness, and dementia. An interesting study reviewed by Campbell and Patterson found that marriage counseling can reduce hypertension (see Ewart, Taylor, Kraemer, & Agras, 1984). Twenty patients with chronic high blood pressure were provided couples communication skills training. Following training, these patients had less marital hostility, fewer displays of hostility, and significantly lower blood pressure than did the control group.

Campbell and Patterson (1995) also reviewed family-based health studies on nutrition. The largest of these studies (Family Heart Study Group, 1994) was conducted in Britain and included 1,200 couples recruited from more than 25 general practices. Each couple received family counseling focused on developing a healthy lifestyle. At a one-year follow-up, the couples had significantly reduced their smoking, blood pressure, and cholesterol levels, lowering their cardiac risk scores by an average of 16%. The authors predicted that this reduction would likely result in an 8% decrease in heart attacks and cardiac fatalities. Campbell and Patterson conclude from this and

other studies that "a number of intervention studies have demonstrated that a family intervention to improve nutrition is effective and results in better outcomes than no intervention" (p. 573).

Dissociative Disorders

I was unable to find any empirical studies on the use of family work with dissociative disorders. However, numerous experts in the field have posited that a family component is a critical part of treating dissociative identity disorder (DID), previously known as multiple personality disorder (Nathan & Gorman, 1998). Nathan and Gorman state that for people with DID, the focus of family work should be the current family rather than the family of origin. This recommendation makes sense because the family of origin is associated with significant and multiple traumas, and contact would promote painful abreactions and encourage splitting. Colin Ross, a leader in the field of dissociation, supports Nathan and Gorman's view in his pioneering book, *Multiple Personality Disorder* (1989). Ross states, "Spouses may participate intensively in therapy or may take an informed and supportive but less involved stance. Either can be satisfactory. The spouse needs to know the diagnosis and to be educated as to etiology, treatment, and prognosis" (p. 294).

Substance-Related Disorders

Various literature reviews have come to the same conclusion about utilizing family work for alcohol and drug abuse: It is an important part of the treatment plan for both adolescents and adults (see Edwards & Steinglass, 1995; Liddle & Dakof, 1995; Pinsof & Wynne, 1995). One of the most beneficial aspects of family involvement is that it greatly increases the likelihood of a substance abuser entering treatment. Edwards and Steinglass (1995) reviewed four studies investigating the role of family members in the assessment of alcoholism. They found in various studies that admission rates ranged from 0% to 31% in the absence of family involvement. Including family members in the assessment of alcoholism led to significantly

increased admission rates, ranging from 57% to 86%. Such a significant increase led Edwards and Steinglass to recommend that "the inclusion of nonalcoholic family members in the assessment phase of treatment be built in as a routine component of alcoholism treatment programs" (1995, p. 485).

Liepman, Silvia, and Nirenberg (1989) also found that family involvement increases the likelihood of admission to an alcohol treatment program. They specifically looked at the efficacy of a technique called *intervention*, in which family members gather to confront a substance abuser. The authors trained 24 families of active alcoholics in how to conduct an intervention. Seven of these families subsequently carried out the formal confrontation. Seventeen of the families choose not to follow through on their training. Of the alcoholics in families that did not engage in an intervention, 17% entered treatment. In contrast, 86% of the alcoholics in the families that did engage in the trained confrontation entered treatment. In addition, the alcoholics who were confronted by their families stayed sober without a relapse for an average of 11 months versus less than 3 months for the alcoholics who were not confronted by family members.

There is also evidence that family work is a useful component of substance abuse treatment across cultures. Szapoczink and colleagues (1988) investigated the usefulness of family therapy with Hispanic drug abusers. They found that when treatment was switched from an individual to a family approach, abstinence rates increased dramatically at both six-month and one-year follow-ups. Specifically, the rates increased from 7% to 80%.

Why Is Family Work Effective?

Incorporating family work into counseling is effective because it allows a counselor to address the client's familial and social environment. As Carlson (1993) succinctly puts it, "Regardless of the number of clients being treated, the family counselor conceptualizes problems in terms of the systems perspective" (p. 63).

Depression provides an illustration. We know that family conflict is correlated with increased risk for depression, impaired recovery, and a greater likelihood for relapse; that depression increases after psychosocial stressors; and that mothers with depression typically have greater amounts of anger and resentment toward their children, as well as greater feelings of inadequacy as a parent, when compared with non-depressed mothers (Prince & Jacobson, 1995). There is also evidence that married individuals who need to be hospitalized for depression have a divorce rate nine times greater than that of the general population (Merikangas, 1984). That is why Prince and Jacobson (1995) conclude, "Close relationships are a potential source of intimacy and social support which can buffer the effects of such events and moderate the relationship between stress and development of symptoms" (p. 379). As such, "failure to address the interpersonal environment of the depressed individual may in part be responsible for the high rates of treatment failure and relapse reported for individual therapies" (p. 383).

Another reason for the efficacy of incorporating family work into counseling is because it adds a psychoeducational component. Family members learn about etiology, prognosis, and treatment options. They are also provided communication training, problem solving skills, and crisis intervention techniques (Pinsof & Wynne, 1995). Psychoeducation works, in part, by increasing the level of support within a family (Prince & Jacobson, 1995). Goldstein and Miklowitz (1995) reviewed six studies comparing a family-based psychoeducational approach with a psychopharmacological/ individual approach to major mental illnesses. They found that the psychoeducational model cut relapse rates by more than 70%.

Finally, incorporating family work into counseling is effective because it allows a counselor to help more than the individual client. Estrada and Pinsof's (1995) literature review indicates that utilizing family counseling with children who have behavioral disorders not only reduces aggression and treatment noncompliance in the children, but also provides direct benefits to parents and relatives. Specifically, a family component in treating conduct disorders and autism allows

parents and other family members to learn effective child-management skills that help to minimize symptoms, to gain a knowledge base that increases self-efficacy, and to reframe the problem away from guilt and blame, thus improving family members' outlook. Epstein, Keitner, Bishop, and Miller (1988) examined the effectiveness of adding a family-counseling component to a standard psychotropic antidepressant treatment approach. The researchers attempted to involve as many relatives of the individual with depression as possible and focused on family communication, problem solving skills, emotional involvement, roles, and behavior management. Interestingly, they found that not only did the family counseling component help clients recover more quickly from depressive episodes, but also that overall family functioning improved.

Conclusion

I began this chapter by stating that family work has come full circle. Family involvement started as a useful tool for a variety of professionals, including physicians, ministers, psychologists, lawyers, social workers, and teachers. With the success of family interventions, family therapy emerged. Over the past 25 years, a group of individuals have come to define themselves as marriage and family therapists and their field of practice as a distinct profession. What had been a modality is now typically seen as a specialty. Over the last quarter century, this trend has caused many mental health specialists to shy away from utilizing their clients' families as a resource.

In recent years a broad array of mental health professionals have begun reclaiming family work and incorporating it into their practice. Counselors employed in elementary, middle, and high schools; mental health centers; rehabilitation settings; private practice; college counseling centers; penal institutions; career and employment centers; hospital and wellness clinics; pastoral settings; and a variety of other work sites are finding that, in keeping with the literature reviewed in this chapter, bringing a client's family into the office can be very helpful.

Why does family involvement work? The literature reviewed in this chapter suggests a number of reasons. Family work

- helps to place the presenting problem within the context of the family system
- permits you to see whether family issues are contributing to or exacerbating the presenting problem
- allows you to utilize and build on family strengths
- has the potential to maximize support and minimize guilt and blame
- offers the possibility of helping more than the individual client

The contributors to this book do not advocate family counseling as a replacement for individual, group, or any other type of counseling. Family work supplements and supports the approach that you have developed (or are developing) with your particular clients for their particular issues in your particular setting. We view family work as another modality you may use in counseling when your professional judgment indicates that it is appropriate and will be helpful. This balanced approach is in keeping with the research which indicates that although involving a significant number of family members increases positive outcomes across a spectrum of presenting problems, family work by itself is not effective with many presenting problems (see Baldwin & Huggins, 1998; Carlson, 1993; Pinsof & Wynne, 1995).

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